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ABSTRACT

In order to comply with Public Law 94-142, Education for All Handicapped Children Act, procedures for planning and conducting screening (identification) and assessment of preschool handicapped children in rural areas were developed. Screening was accomplished by public awareness campaigns, health screening, or school census analysis. In the HICOMP Early Identification Model, county fair sign-up booths and community volunteers were used for screening. The Denver Developmental Screening Test (DDST) was used to make tentative assessments of children's developmental capabilities. Suggestions for organizing a screening campaign included: selecting an agency, school or community group as sponsor; appointing a professional coordinator as administrator; and enlisting volunteers to carry out an awareness campaign and to perform the screening. (Descriptions of The Denver Prescreening Developmental Questionnaire, Guide to Normal Milestones of Development, Rapid Developmental Screening Checklist, CCD Developmental Progress Scale, and The Developmental Screening Inventory, as well as sample forms used in the screening campaign are appended). (MH)

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THE COMP-IDENT FIND/SCREEN PLANNING PACKAGE

A Descriptive Manual and Organizational Guide for Planning and Conducting Child Find/Screen Efforts in Rural Areas

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PREFACE

Developmental problems should be identified before children reach school-age so that alleviation and remediation efforts can be made early when they are most effective. This manual has been written for the preschool administrator or community organizer who desires to determine which children between six months and six years of age are in need of special services, and describes how to conduct a general screening. As the model was developed for rural areas, it is assumed that the screening is being conducted in a community that is in a specific locality whose residents have a sense of commonality. The model might be employed in an urban area if community units can be discerned within it. Although early identification efforts can take many forms, this manual presents a single coherent approach with rationales provided wherever selection has occurred. However, alternatives are suggested so that modifications can be made.

Finding, Screening, and Identifying Children

The Bureau of Education for the Handicapped has proposed a five-step child identification model consisting of: a) public awareness, b) location of potentially handicapped children, c) diagnosis and evaluation, d) delivery of appropriate educational and related services, and e) reassessment of the children's needs and the services that were or are provided.

By finding and screening children, the early identification process initiates a sequence requiring the cooperation of many concerned professionals and community workers, as well as families. Certain distinctions between several related functions in that sequence are

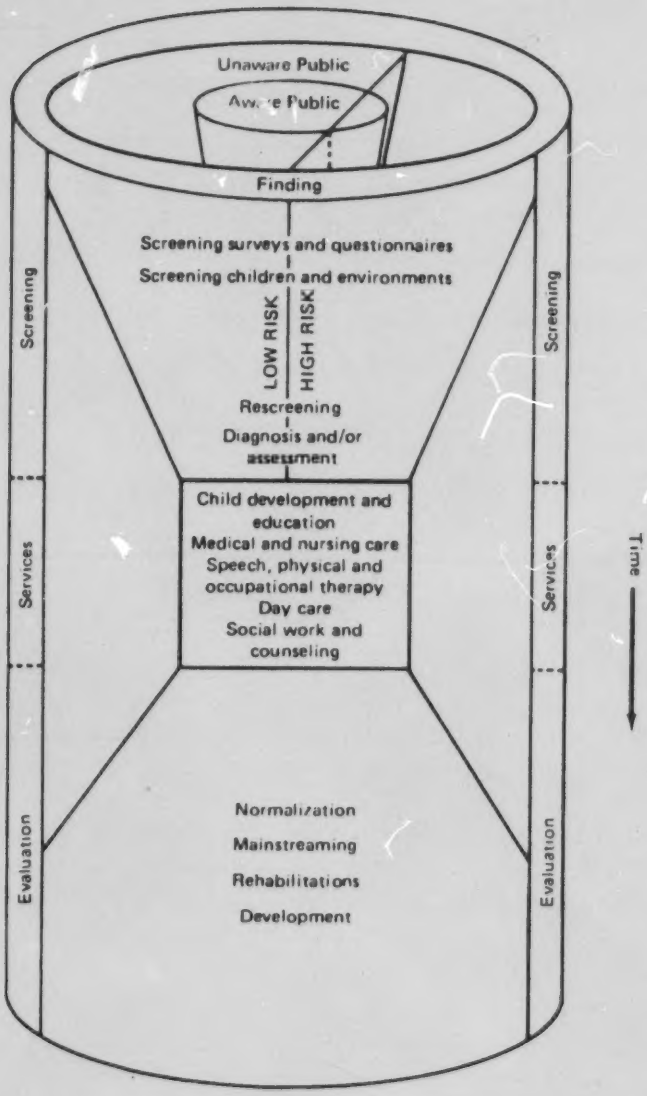

Figure 1. The HICOMP model of early identification

illustrated in Figure 1, that is, step 3 above is partially composed of several sub-steps. After children are located or found, whether by referral, birth listings, school census, or parental initiation, the next step can be either a preliminary survey or an actual screening. Such preliminary reviews typically take the form of questionnaires or interviews designed for parents; clinical judgments by doctors, visiting nurses, social workers, and others; and high risk registries which evaluate such factors as family medical history, social class, and birth complications. Screening, in turn, is not a substitute for more thorough assessment nor a reliable means of diagnosis in and of itself. Figure 1 is drawn as an hourglass to remind us of that important and complex factor, time. While admittedly, the HICOMP model suggests a flow from top to bottom, from awareness to normalization, there is not only the shifting of sands within the glass, but the necessity that it be turned occasionally to sift or move some children to different and currently more appropriate services, and to newly recognize the needs of children previously funneled out as not then notably requiring services.

Such functions as public education and assessment are appropriately continuous throughout time, rather than "before" or "after" such periodic functions as screening. It is assumed that the reader shares this awareness that human services must be viewed dynamically in terms of long-range planning. Nevertheless, time is not merely an expanse: one must work in the present for each child as (s)he is at this point in time.

CHAPTER ONE

THE NEED FOR EARLY IDENTIFICATION*

Free public education is a fundamental right of every American citizen. Nevertheless, the Bureau of Education for the Handicapped has estimated that fewer than 40 percent of the nation's eight million handicapped children (0-21 years) are receiving an appropriate education. In recent years a series of landmark federal laws were written to assist State Education Agencies in providing more adequate services to the handicapped. In 1971 the Education of the Handicapped Act authorized grants from the federal government to the states to stimulate the initiation, expansion, and improvement of educational programs for handicapped children. The "Mathias Amendment" (Public Law 93-380) substantially expanded the federal government's role in 1974, by allocating federal monies to support state efforts in establishing full educational programs for handicapped children, as well as in actively identifying, locating, and evaluating all handicapped children. In 1975, the Education for All Handicapped Children Act (Public Law 94-142) was passed and signed into law. The major provisions of this law are to:

> Provide that all children residing within the jurisdiction of the local educational agency or the intermediate educational unit who are handicapped, regardless of the severity of their handicap, and are in need of special education and related services will be identified, located, and evaluated, and provide for the inclusion

*Much of the material in Chapters 1-5 is taken from "Early Identification," by Karen W. Laub and P. David Kurtz, which appears in J. T. Neisworth and R. M. Smith (eds.), Retardation. New York: McGraw-Hill, Inc., 1978, pp. 243-267.

> of a practical method of determining which children are currently receiving needed special education and related services and which children are not currently receiving such education and services. (Public Law 94-142, Sec. 614. (a)(1)(A), 94th Congress, S.6, 1975, p. 12)
>
> The provision of, and the establishment of priorities for providing a free appropriate public education to all handicapped children, first with respect to handicapped children who are not receiving an education, and second with respect to handicapped children, within each disability, with the most severe handicaps who are receiving an inadequate education. (Public Law 94-142, Sec. 614. (a)(1)(C), 94th Congress, S.6, 1975, p. 13)

In order to be eligible for federal grants, state and local education agencies are required to demonstrate that all children living in their area who are in need of special educational and related services are identified, located, and assessed. Each state is mandated to design a child location plan for all handicapped children between the ages of three and eighteen years by 1978, and between the ages of three and twenty-one by 1980. The plan must describe how each state intends to: a) locate and screen all handicapped children, b) diagnose those children using bias-free assessment procedures, c) devise procedures to ensure due process and confidentiality requirements are met, d) design an individualized program for each handicapped child in need of service, and e) periodically evaluate each component of the plan.

Although federal law requires the locating of all children with special needs, it does not define how these children are to be identified. But trying to determine the number of handicapped children that live in a given community is by itself a task with a not-so-simple solution. In the first place, the answer must vary with the degree of severity or impairment required to define a condition as handicapping. Further the answer also varies according to the age of the children regarding whom the question is asked. For example, in one country-wide effort to exhaustively locate all handicapped children under the age of five years, the rate of handicaps found increased with each additicnal preschool year (Sower and Covert, 1975). The yield from school agency, and physician referrals, a mass media campaign, and letter, phone, and questionnaire contacts with parents was 1.9 handicaps per thousand children at age two years; and the corresponding figures for ages three, four, and five years were, respectively, 4.2, 8.5, and 9.4. (The national special education rate is 10.6 per thousand school-aged children.) It appears to be the case that some handicapping conditions only become evident and/or a problem in environments more common to older children, and that some handicapping conditions are initially invisible given our current detection skills.

Nevertheless, it is reasonable to assume that many recognizable handicapping conditions, which could be limited or remediated, currently are not detected in the preschool years. Werner, Bierman, and French (1971) evaluated at ages two years and ten years, 1,000 children who had received good prenatal care in a multiracial, multiethnic community. About 12% of the two-year-olds they evaluated were identified as handicapped, whereas about 33% of the ten-year-olds had some identifiable

problem. (This later evaluation revealed children one or more grades below their chronological age group or with IQ's below 85, children with hyperkinetic symptoms or severe behavior problems, and children with other developmentally disadvantageous conditions.) The early recognition yield from various sources of information concerning these children was examined. According to birth certificates and hospital records eight of ten conditions easily detectable at birth were recognized then, in contrast to only five of 21 defects which require special diagnostic skills. Physicians and agencies identified only 37 additional children with problems before the special screening at age two years, while the screening revealed 75 children not previously identified as handicapped.

CHAPTER TWO

WHAT IS EARLY IDENTIFICATION?

Screening is an assessment function which must be differentiated from other assessment functions such as program evaluation and individual diagnosis. The screening is not intended to make diagnosis or to substitute for comprehensive assessment; instead, it is a procedure for reaching a large population to identify children who have a high probability of having problems which can be alleviated through early intervention. Alternately stated, screening is a procedure which categorizes children as possibly handicapped or delayed or as not currently handicapped or delayed, and is an attempt to identify children in need of further assessment. A screening procedure does not indicate that a child is handicapped or delayed. It errs in the direction of false positives, rather than in the direction of false negatives (i.e., it "fails" children who are not handicapped or delayed in preference to "passing" children who are handicapped or delayed).

The follow-up screening (rescreening), as with the follow-up or professional referral and self-referral, can take either or both of two forms, diagnosis and assessment. Diagnosis involves medical labeling or educational categorization according to etiology, case characteristics, and/or proposed treatment group. Assessment per se involves the definition of the individual's, and in some cases the family's, strengths and weaknesses and the formulation of a plan for treatment. Assessment is always an ongoing function, while diagnosis is a desired, but optional function. The existence of developmentally-integrated services available to delayed and non-delayed individuals eliminates the necessity for the usual ordering of diagnosis followed by assessment.

In addition to discriminating among screening, diagnosis, assessment, and evaluation, Lillie (1975) suggests a function which he calls finding. Before a child can be screened, (s)he must be found, i.e., someone must bring the child to a screening location or provide a child's name and a way to contact that child. For example, stimulating referrals is a child-find method, as is obtaining a preschool census. Thus, an essential component to screening is a method for notifying and encouraging parents to allow their child to participate. Second, a valid screening test which can be quickly, easily, and reliably administered to large numbers of children must be available. Once the child has been found, and the second condition met, the child may then be screened.

Developmental Screening

Developmental screening stems from the public health model of using mass screening to detect diseased individuals. The purpose of the early developmental screening is to identify children with significant deviations in cognitive, language, social-emotional, and motor development. The screening is not intended to make diagnosis or to substitute for comprehensive assessment; instead, it is a procedure for reaching a large population to identify children who have a high probability of having problems which can be alleviated through early intervention. Recently several projects conducted pilot developmental screening programs.

Project Search (Makolin, 1975) determined that extensive efforts to stimulate agency and physician interest as well as mass media advertising involving pamphlets, radio releases, and newspaper articles were generally ineffective in locating three and four year old handicapped children. As a result, rather than searching exclusively for handicapped youngsters,

the project decided to identify and screen all children in the appropriate age range. In addition to mass media, direct mail flyers were used to notify parents of free child checks to be conducted at several "clinics" set up in churches throughout the community. Appointments were made for each child and children under three years of age as well as those who were known to be shy were screened in their home. The Denver Developmental Screening Test (DDST) (Frankenburg, Goldstein and Camp, 1971) was employed. This procedure, combined with referrals and the screening of children attending Head Start and Day Care, resulted in an estimated 27% (1,058) of the community's three and four year olds being screened. Approximately 15% of the children screened were found to need retesting. The retesting results from the DDST indicated that approximately 5% (excluding kindergarten age children) be referred for extensive psychological assessment.

A rural school district used mass media, letters, and telephone calls from indigenous paraprofessionals to identify and encourage parents of children, zero to five years of age, to participate in a multi-disciplinary diagnosis (Jackson, Stamps, Cleveland, Arthur, and Nelson, 1973). There was no initial screening of the children. Of the 18 children for whom educational intervention was recommended, 14 children were enrolled either in Head Start or special education classes.

One of the few data based early identification projects was conducted by the PEECH Project (Zehrback, 1975). Initially, letters and meetings with physicians and agency personnel were used to stimulate referrals. However, this routine recruitment method was almost completely ineffective. After one year, 17 referrals had been received or about 14% of the 120 projected handicapped preschoolers in the area.

Mass mailings informing parents of a new program for children with handicaps, which briefly described possible handicapping conditions and encouraged parents of children who displayed any of the conditions to call, did not result in even one telephone call. An open house at the school failed to attract large numbers of preschool parents. A public awareness campaign which included radio and television announcements, and newspaper articles may have sensitized the community and alerted a few parents; however, only 15% of the parents whose children were screened, idenfitied mass media as the source of information. The most effective approaches were notices sent home through children already in school and a house to house telephone survey informing parents of free developmental checkups for all children, three to four years of age. The screening included a medical history, visual and auditory acuity tests, a speech articulation test, and an assessment of gross and fine motor, social, and cognitive-verbal development.

The results indicate that a total of 762 children were screened from several communities. It was estimated in the smaller towns (under 5,000) that 80% to 100% of the predicted preschool population was screened. However, only 25 to 40% of the target population could be screened in two larger communities because of a lack of manpower necessary to implement the model. Seventy-one percent of the children passed the screening without difficulty. Approximately 10.9% were referred directly for a complete assessment, 10.5 for speech and/or hearing evaluations and 5% to family physicians. Based on follow-up assessments, 13.8% of the children were determined to need some form of service. There is no indication of the number of mentally retarded children that were identified.

With the cooperation and assistance of regional personnel employed by the state department of education and the support of the local school district, Laub and Kurtz (1976) selected a small rural community to implement a child find project for all children one to six years of age (the school district did not offer a kindergarten program). A master list of children under six years of age was prepared from school census lists. A three-day-long screening schedule was set up for the original 191 children listed on the census. Letters were sent to each parent describing the developmental checkup and informing them of their appointment time. Parents were asked to complete and return a self-addressed post card indicating either: a) I intend to bring my child at the appointed time, b) I intend to bring my child but call to arrange another time, c) I would like to bring my child but I need transportation--please call, or d) I would like more information. Parents who indicated b, c, or d on their cards as well as parents who did not return the cards received telephone calls to answer questions and to encourage them to make an appointment to bring their preschoolers.

The screening occurred in a church basement where each child was screened individually by a trained paraprofessional using the DDST (Frankenburg, Goldstein, and Camp, 1971). The test results were interpreted to parents immediately after the screening by professionals. Arrangements were made to rescreen children in their homes whose results were "questionable" or who had failed to pass the screening.

The results indicate that 40% of a rural preschool census population can be screened simply by sending a letter with a predetermined appointment. Further, 43% of the children identified came from this group. Another 20% of the census population was encouraged to participate as

a result of a telephone call. However, most of the parents from this group whose children did not pass the initial screen refused the rescreening. An additional 14% of the parents who attended the screening were self-referrals. Children from this group appear to be least in need of screening. An estimated 80% of the community preschoolers attended the screening of which approximately 10% were identified.

CHAPTER THREE

CONSIDERATIONS IN PLANNING EARLY IDENTIFICATION

The purpose of early developmental screening is to identify children with significant deviations in cognitive, language, social-emotional, and motor development. Rather than making diagnoses or substituting for comprehensive assessment, the intention of screening is to reach a range population to identify children who have a high probability of having problems which can be alleviated through early intervention. Essential to this approach are methods for notifying and encouraging parents to allow their child to participate, and a valid screening test which can be quickly, easily, and reliably administered to large numbers of children.

Frankenburg (1972) has suggested seven considerations prior to screening; a) the frequency of the condition being screened for; b) the seriousness of the condition; c) the availability of effective treatment; d) timing the screening; e) the detectability of the condition; f) the value of early detection; and g) cost-effectiveness factors (and presumably, other matters of practical concern).

Although the emphasis of this manual is on developmental screening, some attention should be paid to screening for other conditions, as the same considerations apply. More important, looking at other efforts illustrates the adaptability and utility of the screening model itself.

To begin with, one must decide what conditions to screen for, since, in practice one can rarely identify, nor would wish to identify, all anomalies including oversized noses and crooked fingers. Taking heritable diseases as an example, however, every human being is estimated to carry 5-10 genetic diseases (Rimoin, 1975) which may be rare recessive conditions showing no effect upon the carrier, but carriers of the same

could be identified through screening adults (e.g., tay-sacks disease, sickle cell anemia). Public education might necessarily precede screening for these conditions.

Similarly one might arrange developmental screenings so that they immediately precede the opening or expansion of appropriate service programs. It has been rumored that some Head Start programs select children to be served and then try to define 10% of them as handicapped in order to meet government requirements. Clearly it would be better to screen community children and thus locate a core of handicapped children around whom a developmentally integrated program could be built. It may be argued, of course, that the incidence of a condition must be established before resources will be made available for the treatment of that condition. Certainly this is the case of newly recognized conditions or for populations where the condition is unknown. This is certainly not the case for developmental delay or "handicaps" in general, where it is the other considerations which present delemmas.

In timing the screening one should also consider "the interval between which the condition can first be detected with a screening test and the time of optimal results from treatment" (Frankenburg, 1972). For example, phenylketonuria must be diagnosed in the first month of life for optimal treatment, as treatment initiated after that time is significantly less effective.

Another timing consideration is the possible need for periodic or recurrent screening. This may not only be necessary so that conditions which become evident with increased maturity can be identified, but also so that individuals who are no longer subject to the condition can be recognized as no longer in need of treatment.

Cost-effectiveness data for various child-find approaches and screening procedures is of obvious importance for practical reasons, especially planning. However, judgments will necessarily vary regarding what is a reasonable cost for what is yielded in identification. Certain biochemical screenings cost only pennies, but these sometimes yield few cases due to low incidence. For example, phenelketonuria is routinely recognized through sampling the blood or urine of newborns and performing a simple analysis at low cost, but the incidence of phenlketonuria is only 310 new cases in the U.S. per year. It is not only reasonable to ask whether even this low cost is justified (although it most certainly is to the parents of afflicted individuals), but questions might be raised about ways to more efficiently organize services. For example, regional centers for biochemical screening have been advocated with the hope that an increasing number of conditions would be diagnosed there at reduced cost.

There is a clear necessity for more research to compare identification methods in terms of their cost-benefits, as well as a need for public discussion regarding the commitment of our national resources to screening. Obviously, the value of early identification depends upon how effectively we can treat individual conditions and at what further costs and benefits.

Meier (1972) has noted the need to compare the cost-benefit of screening based upon high risk factors and screening based upon the condition being somehow discriminably demonstrated in indivuals. Lilly-White (1972) suggested, for example, that the high risk approach to auditory screening of infants has been the most promising approach to date for that area of disability. Vision screening, on the other hand, appears to be progressing better through the direct observation of children,

including preliminary screening by parents (Lin-Fu, 1971). Observational and high risk approaches could, of course be used in tandem to funnel cases through a sequence of screenings ending in complete assessment or placement.

CHAPTER FOUR

APPROACHES TO EARLY IDENTIFICATION

Public Awareness

Documentation of early identification projects and conceptualization of early identification models is quite limited. To review briefly, the Bureau of Education for the Handicapped has proposed a five-step child identification model: a) public awareness, b) location of potentially handicapped children, c) diagnosis and evaluation (i.e., screening, assessment, and diagnosis), d) reassessment of the children's needs and the services that were or are provided (i.e., evaluation). States are encouraged to follow these steps in developing their state's plans. To date most discussion and project efforts have focused on the public awareness step while providing few guidelines for the subsequent phases. It is assumed that bombarding the public with various forms of advertising is an important first step in locating and eventually serving handicapped children.

The purpose of the public awareness campaign is to use a wide range of public media to increase understanding of the importance of referring handicapped children who are not presently being served. Many different forms of the media can be employed, e.g., radio and television public service announcements, newspaper advertisements, brochures sent home with school children and distributed at public places, direct contact with organizations, letters and telephone calls to parents, etc. As Hodskins (1975) points out, the best method of deliverying a message to vast members of people in the modern American culture, is by advertising techniques, i.e., mass media, direct mail, and promotional activities.

Head Start has employed a public awareness campaign to facilitate the recruitment of handicapped children in order to comply with requirements that at least ten per cent of the nation-wide enrollment in Head Start consists of children who are handicapped and require special services (Public Law 92-242). The goal of encouraging local Head Start programs to use advertising is to inform the general public that Head Start centers now extend their services to handicapped children and persuade persons to refer children with special needs for services so that their development may be enhanced. "A Manual for Head Start Personnel in Recruiting Handicapped Children" (Hodskins, 1975) is expressly designed to offer guidance to local Head Start programs in planning their recruitment efforts and even includes the exact wording of news releases and letters as well as bumper stickers, buttons, and doorknob flyers.

As early as 1972, Idaho conducted a child find project for all exceptional children who were not receiving an educational program. A request that school and agency personnel and parents report such children resulted in only nine referrals. It was determined that a more intense, extensive public awareness campaign was needed. Several staff and an extensive network of volunteers conducted a statewide public information campaign using radio and television announcements, newspaper releases, posters, flyers sent home in bank statements, flyers stuffed in grocery sacks, letters to parents, endorsements from public officials, and personal contact to increase awareness and stimulate referral of the target population. Approximately 280 out-of-school children were found in the 19 sample counties. Thirty-four per cent of these children were handicapped of which over half were determined to have some form of mental

retardation. There is no indication as to how thorough the project was in detecting the handicapped children in the sample areas. Workers direct contact with the referral person (such as agency personnel, ministers, physicians, and parents) accounted for 73% of all referrals. Only 17% were referred as a result of mass media advertisements. Idaho intends to extend the volunteer based public information campaign to include the identification of preschool exceptional children.

Health Screening

In 1967 Congress enacted the Title XIX Amendment to the Social Security Act which is entitled Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT was intended to expand health services to 11.5 million Medicaid eligible children; however, it was not until 1974 when Congress added a penalty clause for states which failed to implement the program that it was offered in most states. The purpose of the program is to bring needed health care services to children who are not receiving it. The screening component is to provide a periodic, quick, and inexpensive test for detecting potentially handicapping medical, psychological, and social conditions. Children thought to have a problem receive a thorough diagnosis to determine the exact nature and extent of the condition. Each child with a diagnosed problem is to receive appropriate treatment including "medication, surgery, counselling, physical therapy, speech therapy, special educational placement, and a variety of other interventions which can remove or alleviate the problem" (Frankenburg & North, 1974, p. 17).

Four EPSDT demonstration projects used a common data base to determine the cost effectiveness of alternate modes of case find, screening, diagnosis, and follow through activities. A high level of

developmental delays were detected. In one project 40% of the children demonstrated at least one lag in the areas of language, cognition, vision, motor response, and memory. Another project found that 85% of the 806 children screened had one or more developmental problem.

School Census

The collection of the school census is an exacting duty required by law in all states. The purpose of census taking is for checking compliance with compulsory attendance laws and to predict school enrollments. An additional function can be the detection of exceptional children. Most school districts are required to conduct a census once every three years and 26 states are mandated by law to take a statewide census that includes exceptional children (Ohrtman, 1975). Census forms most frequently include the categories of mental retardation, emotional disturbance, blindness, deafness, and physical handicaps. The age of handicapped children being identified from census data range usually from birth to 15 years. The two most common methods of census collection are door to door interviews and questionnaires mailed to the home.

CHAPTER FIVE

ISSUES IN EARLY IDENTIFICATION

Most early identification projects have not included systematic evaluation of their procedures. Before definite approaches can be delineated, a number of issues must be examined. These issues include a) the population to be screened, b) mass campaigning vs. personal contact, c) outside agency vs. community-based efforts, and d) referral vs. screening modes.

Populations: "Handicapped" vs. All Children Focus

Early identification projects which have "advertised" specifically for handicapped children have been successful in stimulating referrals of children who are screened and, if warranted, thoroughly assessed. (Idaho's Exceptional Child Survey and California's Citizens Alert and Appeal to Help Find Individuals with Exceptional Needs are examples.) Opponents contend that this procedure tends to stigmatize child find and fails to detect the more subtle but developmentally important handicaps. Parents who have a slight suspicion that their child is handicapped may be reluctant to participate and thus acknowledge that their child is handicapped. Many parents are unaware that their child is handicapped and therefore they may dismiss the project as inappropriate for their child. Professionals who suspect that a child is handicapped may be cautious to refer the child for fear that (s)he will be stigmatized. Projects PEECH (Zehrback, 1975) and Search (Makolin, 1975) found that "advertising" exclusively for handicapped children was not as effective in detecting handicapped children, particularly in the mild range, when

compared to a normalizing approach of checking the development of all children in the appropriate age range.

Mass Campaign vs. Personal Contact

Although BEH has proposed a five step child find approach with the first step involving public awareness, there is not substantial validation for the use of mass media in early identification. The Idaho Exceptional Child Survey (Schrag, 1975), which made extensive use of a range of mass media, discovered that 75% of the children were detected as a result of workers' direct communication with the referral person. The HICOMP project (Laub, Kurtz, & Bagnato, 1975) reported very few children were identified through routine referral procedures and mass media efforts. Personal contact with parents and developmental checkups for all children in the appropriate age range were more effective. Zehrback (1975) conducted what is perhaps the most systematic investigation to determine the most efficient and effective procedures for early identification. Using a multiple baseline design, he found that conventional referral systems, letters to parents, open school meetings, and mass media were almost completely ineffective in uncovering the target population. In contrast, more personal communication via flyers sent home through school children and, in particular, telephone calls to the homes of all preschoolers were highly successful in turning out large numbers of preschoolers for developmental screenings.

Approaches which have reduced the social distance between the family and the agency (e.g., telephone calls and common messenger) have been influential in attracting large numbers of referrals and children for developmental checkups. Since most parents and professionals are

unfamiliar with the practice of early identification, it is essential to communicate in ways which help them to understand and incorporate the program into their own values. Although personal communication appears to be effective in finding the target population, such a procedure requires more time and resources and thus must be evaluated to determine the cost efficiency.

Outside Agency vs. Community-Based Efforts

The success of early identification is also influenced by who conducts the project. Should a single or outside agency assume sole responsibility for organizing and carrying out the project or should the community be encouraged to assume a major role in the process? Although community involvement can provide additional manpower, community facilities, money, and other valuable resources, the time required to organize and train community personnel in some cases outweighs these benefits. However, early identification is a new concept in which people may be hesitant to participate if they perceive that it is imposed on them by an unfamiliar agency. Social scientists (Litwak and Meyer, 1966) suggest that resistance to a new service is likely to be reduced if the project has the strong support of trusted community members. To illustrate, a rural school district had near perfect attendance of the community's 84 preschoolers at a multidisciplinary diagnosis when a combination of mass media, letters, and telephone calls from indigenous paraprofessionals were used to contact parents (Jackson, Stamps, Cleveland, Arthur, and Nelson, 1973). Several projects (Laub, Kurtz, and Bagnato, 1975) have used community members in a variety of roles such as telephoning parents regarding developmental screenings,

locating screening facilities, and even screening children under the close supervision of professionals. Schrag (1975) found that professional and community volunteer direct contacts with the referral person were the most effective means of stimulating referrals. On the other hand, with minimal community involvement, HICOMP, in cooperation with a state regional education agency, successfully conducted a community wide developmental screening in a rural town (Laub and Kurtz, 1976). Although there are indications that community support is an important ingredient in comprehensive child find, there is no comparison between the use of external agency staff and community personnel to determine which is more effective and efficient.

Referral Mode vs. Screening Mode

A final issue in seeking alternative early identification methods is how the presence of developmental delay is detected. The BEH model which emphasizes the use of mass media campaigns and states which use census data collection as the major method for locating handicapped children in essence rely on the parent, agency, and physician for detection and referral of handicapped children. These survey methods are similar to conventional referral procedures except they are conducted on more intensive and broad scales.

Rather than relying exclusively on the referral process, some projects (Laub & Kurtz, 1976; Makolin, 1975) have conducted outreach efforts designed to check the development of all children using a simple objective screening instrument such as the Denver Developmental Screening Test. Zehrback (1975) found that there is a need for both professional referral and developmental screenings. Agencies and physicians were

successful in detecting children with moderate or overt problems, and screening identified children with less obvious developmental delays.

Neither of these approaches, however, are comprehensive models for detecting most, let alone all, preschoolers with handicapping conditions. The optimal solution may be a health maintenance program for all children. The Early and Periodic Screening, Diagnosis, and Treatment is a step in this direction. However, it is exclusively for children eligible for Medicaid and, at least to date, includes a fairly thorough physical examination but the developmental assessment appears to be underdefined and thus frequently inadequate to detect developmental problems other than in cases of obvious handicaps. The Brookline Early Education Project has been attempting to develop a model health maintenance program for children (Pierson, 1974). A primary goal of the project is to provide a series of free health and developmental examinations to insure that no child progresses through the preschool years with an undetected handicap. Although this project appears promising, at this time, there is no demonstrated health maintenance model nor does there appear to be a concerted effort at the national level to provide such a program for all children. While noting that screening is a poor substitute for health care, Hobbs (1975) urges that, "We accept mass screening programs as a current necessity, but we prefer to use screening programs displaced by health-maintenance programs for all the nation's children" (p. 91).

CHAPTER SIX

THE HICOMP EARLY IDENTIFICATION MODEL: AN OVERVIEW

The guidelines comprising the HICOMP Early Identification Model for rural areas were formulated via the field testing and evaluation of various screening options which were developed to meet rural needs. Three such screening options are briefly described below, specifically, the county fair screen, the shopping center screen, and the community-based screen. It should be remembered that each of these options serve only as a model, and that combinations of any of them are recommended to best meet the capabilities and needs of various rural localities.

County Fair Screens

County fairs provide an excellent gathering point for rural families within a specified geographical region. Since it is difficult to conduct actual screenings in such a distracting environment, parents can merely indicate if they are willing to have their child screened at a later date. In attracting parents and children to the sign-up booth, a free toy raffle for young children can be quite effective. Parents then quite willingly fill out tickets with their name and address in hopes of winning one of a number of the toys on display at the booth. All parents who indicate an interest in having their child developmentally screened can then be sent an instrument such as the Denver Prescreening Questionnaire (see Appendix A). Follow-up screening is done by trained volunteers for those children who did not pass the prescreening.

Community-Based Screen

The community-based screen was developed for small communities with a population under 5,000. The goal is to gain support of community

leaders who, with the strength of indigenous community volunteers, screen all children one through five years of age. With this method, volunteers are organized into committees for telephoning, transportation, publicity, site location, screening, and other functions. A staff member can assume the role of training and monitoring the committees to ensure performance according to plan. Parents are contacted by telephone, public announcements, posters, and flyers which are sent home with school children, announcing the availability of a free developmental check-up. The screening is conducted within a church community hall, or school with transportation, baby sitting, and refreshments provided. The actual screening is conducted by trained volunteers utilizing the DDST under the supervision of a professional. For children who pass, an appropriate letter is sent to the parents. For children who do not pass or whose results are questionable, a professional informs the parents by telephone that the results were inconclusive and that it would be desirable to do a further assessment of their child in the home.

In order to conduct wide-range screens within a community, many factors must be taken into consideration, i.e., a needs assessment of community resources, size of the projected screen, manpower, site requirements, advertising, mailing, transportation, and the screening instrument itself (Figure 2). In subsequent chapters, this manual details the many factors which must be taken into consideration and provides methods of implementing the various aforementioned child screen options.

The Denver Developmental Screening Test

To date, screening tests for developmental lags have derived their validity from the traditional mental tests, and, therefore, share their

1. Types of screens

   a. Regional Screens . . . . 200 to 500 (boroughs/towns)

   b. Regional Screens . . . . 1,000 to 5,000 (counties)

   c. Focused Screens . . . . 50 to 100 (townships/villages)

2. Decision on Area--size of area and availability of human service agencies to provide follow-up services

3. School Census--Children between 1 year and 5 years

   Joint sponsorship with various agencies

   If no census, then canvass community

4. Manpower--IU; MH/MR; Easter Seals; Association for Retarded Citizens; March of Dimes; Church groups; Women's Auxiliary; Head Start; UCP

5. Advertising--Radio; T.V.: Newspapers; brochures in malls; church bulletins

6. Site--Requirements; location; layout

7. Mailing--letters; appointment cards; Master Schedule Forms

8. Telephoning--check on appointments and scheduling; Master Schedule Forms

9. Training Phase--DDST training procedures

10. Screening process--screeners; reception area; babysitting; assessments measures; explanation of results

11. Followthrough--letters to parents; agency placement; home-assessment; placement assessment

Figure 2: Organization factors in conducting community-based screens

predictive limitations. Eventually, effective screening may be based upon such variables as rapidity of habituation (Lewis, 1969) or on state-sensitive behaviorally expanded neurological examinations like the Neonatal Behavioral Assessment Scale (Brazelton, 1975). In the meantime, it is not an insignificant accomplishment that it has been possible to develop screening instruments that agree well with the more extended tests regarding current developmental status. While it is as reasonable to screen environments as to screen children, convenient instruments to screen the specific environments of infants and preschoolers are uncommon (one exception is the Calwell home inventory). Therefore, the instruments typically used for early identification are for screening children. Excellent reviews of screening instruments have been provided by Meier (1975) and a number of them are described in Appendix A of this manual.

The HICOMP project utilizes the Denver Developmental Screening Test (DDST) to obtain tentative estimates of each child's developmental capabilities. This screening test, developed by Frankenburg and Dodds (1967), is chosen because, unlike most screening tests available, the DDST has been subjected to extensive and intensive reliability studies. Administered by a trained paraprofessional, it is designed for use on children from birth to six years of age. It consists of 105 items and measures functioning in four areas--gross motor, fine motor-adaptive, language, and personal-social. The DDST allows for many items to be credited as passed on the basis of parental report, when the behavior can not be observed directly. The test takes approximately 20 minutes to administer, and requires no elaborate materials. For the most part, the scale can be presented with a few simple items such as paper and

pencil, yarn, a rattle, a tennis ball, a small bottle, raisins, and blocks, available in kit form. The high test-observer agreement, stability of test items and validity shown for the DDST (Frankenburg, Goldstein, and Camp, 1971), as well as the ease with which the DDST can be learned, administered and interpreted, make this a useful test for screening for developmental deviations in preschool-aged children.

CHAPTER SEVEN

GENERAL ORGANIZATION

Agency

Typically an agency, school, or community group is the sponsor of the early identification project. To insure success of the project, an agency must: a) have the support of other human service organizations, civic groups, and community leaders; b) identify follow-up services that can be provided to children found to be handicapped; c) employ a professional staff member who can organize and coordinate the effort; d) supply manpower (staff or volunteers) to assist in conducting the screen; and e) have a financial basis for supporting the costs of the screen.

Professional Coordinator

The success of the project is dependent largely on the ability of the professional to gain the support of community leaders and agencies, to attract and train volunteers to provide competent manpower, to coordinate the various task forces to maximize the timely flow of activities, to relate to parents (particularly of handicapped youngsters), and to follow up on children identified as being handicapped to insure an appropriate form of intervention. The coordinator may be a child development specialist, early childhood educator, social worker, teacher, special educator, school psychologist, nurse, physician or other appropriate professional. The coordinator must be competent in motivating people to work on the project, arousing community interest, training and supervising the activities of groups, providing support and encouragement to the workers, and coordinating a range of events. In addition, (s)he

must be knowledgeable of child development, handicapped children, and assessment procedures as well as be highly skilled in relating to parents. Finally, a thorough familiarity and good working relationship with other agencies is necessary.

The coordinator assumes primary responsibility for making major decisions and supervising the accomplishment of most tasks. The role of the coordinator in supervising task groups will differ depending on the level of competent volunteer leaders that are available. If several motivated, highly talented leaders are willing to serve as chairpersons of the major task groups, then the coordinator can assume a less direct role in supervising the task groups. On the other hand, in instances where few, if any volunteers with leadership abilities are available, the coordinator must play a direct leadership role in the groups. In either case, the professional must organize the groups and coordinate their activities. Thus, (s)he must be in contact with the groups on a regular basis to determine progress, and give direction and support. Volunteers need considerable reinforcement and the awareness that the professional is truly involved in the project. The specific decisions and activities the coordinator must assume are summarized in the Early Identification Time Table (Figure 3). Each decision and task is described in detail in the chapter entitled Early Identification Process.

Volunteer

This early identification approach encourages the use of volunteers to assist in carrying out many of the routine and not so routine activities. Volunteers have been successfully used to help conduct

Time Line	Project Schedule	Tasks Completed	STEP	Decision and Task	Personnel
Day 60			1	Determine whether to conduct screen	Coordinator and agency staff
Days 59-47			2	Determine feasibility of screen	Coordinator and agency staff
Day 46			3	Decide where (geographic area) to hold screen	Coordinator
Day 46			4	Decide when to conduct screen	Coordinator
Day 45			5	Decide how many children to screen and screening days required	Coordinator
Day 45			6	Decide screen dates and set project schedule	Coordinator
Day 35			7	Organize volunteers	Coordinator and community leaders
Day 28			8	Select screening site	Volunteers
Days 20-18			9	Prepare letters and mail	Volunteers
Days 17-7			10	Recording parent replies	Volunteers
Days 20-18 and 6-3			11	Place ads	Volunteers
Day 10			12	Train screeners	Coordinator
Days 6-3			13	Telephoning nonrespondents	Volunteers
Day 5			14	Prepare Denver Score Sheets	Volunteers
Day 1			15	Prepare screening site	Volunteers
Day 0			16	Receptionist duties	Volunteers
Day 0			17	Babysitting and transportation duties	Volunteers
Day 0			18	Conduct screening	Volunteers
Day 0			19	Make interpretations	Coordinator
			20	Tabulate screen results	Coordinator
			21	Rescreen	Coordinator
			22	Make referrals	

Figure 3: Early identification time table.

CHAPTER EIGHT

EARLY IDENTIFICATION PROCESS

Duties of the Coordinator

The overall supervision of the entire project is the responsibility of the coordinator, but this duty may be shared with a volunteer who is designated as general chairperson. The suggested roles and duties contained here are meant to be guidelines only, as there must be great flexibility in the tasks the coordinator will perform, as well as the volunteers, in regard to the planning and carrying out of the screen itself. Dictating the need for flexibility will be such things as the competence of personnel and their availability, local conditions, and the time available for carrying out particular assignments.

Responsibilities of the coordinator:

1. To make preliminary decisions in regard to who will be screened as well as how the screening will be carried out.

    1.1 To decide upon a general geographic area to be served by the screen.

    1.2 To obtain the most recent census data available for that area.

    1.3 To decide approximately how many children will be screened (this manual is designed for a planned screening of 100-300 children).

    1.4 To decide the number of days needed to conduct the screen, and the approximate dates for such.

    1.5 To order the instruments and materials.

    1.6 To prepare the master record forms necessary for the screen.

advertising campaigns, locate screening sites, call parents, be receptionists, greet parents, provide transportation and babysitting services, and actually screen the children.

There are several advantages to using volunteers. First, they dramatically reduce the costs of the project. Second, the involvement of local volunteers helps to sanction the screening and make the community more aware of the effort. Obviously, there are disadvantages to volunteer participation such as it takes time to organize and train them, some volunteers may be unreliable, and so on. It is not essential to use volunteers. If staff from your agency or other agencies in the community are available, they can readily be used as the source of manpower or at least to supplement volunteer help. Thus, in referring to volunteer workers, staff members can be substituted.

The specific tasks the volunteers can perform are summarized in the Early Identification Time Table (Figure 3) and described in detail in the chapter entitled Early Identification Process.

Scope of Screen

The community-based early identification projects have been conducted exclusively in small rural communities. The approach is designed specifically for small geographic areas which have a preschool population of 100-300. The geographic area should be an identifiable location such as a town or an elementary school.

2. To recruit manpower--Ideally the screen would receive the support and assistance of agencies such as Easter Seals, Association for Retarded Citizens, or the March of Dimes, but other volunteers can be recruited.

2.1 Contact people familiar with the area such as school principals or ministers for their advice and to solicit their support.

2.2 Clubs provide an excellent source of volunteers. These groups should be apolitical--not identified with controversial causes, and should be committed to the idea of a screen.

2.3 Groups whose members are available during the day are preferred such as the PTA, Women's Clubs, Senior Citizens' groups, Church groups. Girl Scouts, Boy Scouts, and High School service groups might also serve on certain committees.

3. To train committee chairperson and supervise the work of each committee.

3.1 To decide with each chairperson the amount of help you need to provide to train the members of each committee.

3.2 To provide each chairperson a schedule of dates and deadlines.

3.3 To prepare the materials each committee will need.

3.4 To schedule meetings and check progress by telephone or written program reports.

STEP 1

Objective: Decide whether or not to determine the feasibility of conducting a community based screen.

Personnel: Agency staff and coordinator

Task: The agency must make a general commitment to study the feasibility of conducting a community-based screen. This commitment must include a willingness to contribute coordinator time, some monies, and a determination to see that children identified as handicapped receive follow-up services.

Time: Day 60

STEP 2

Objective: Obtain information to determine the feasibility of a screen in a given geographic area (the area should include 100-300 preschoolers).

Personnel: Coordinator

Tasks:

1. Conduct a needs assessment of local agencies to determine if they provide services for preschool handicapped, what types of services they offer, the age range and numbers of children they service, and how many openings they have for additional children. Before a screening can be conducted, there must be some assurance of providing appropriate services to children identified as handicapped. The Agency Needs Assessment (see Appendix B) offers an up-to-date estimate of the availability of follow-up services, and it can also serve to inform agencies of the goal of the project and solicit their support. The assessment is sent to all agencies which you think may be serving handicapped children and their families. When the forms are returned, the

coordinator must analyze the types and locations of available services. Follow-up telephone calls may be necessary to clarify the exact service an agency offers and the number of likely openings available. Areas which have more follow-up services available receive a higher priority for the screen.

Time: Day 59 - send out Agency Needs Assessment;
Day 47 - Agency Needs Assessment is returned and analyzed

Resources: Needs Assessment Form; Names and Addresses of agencies.

2. Determine if recent (2 years old or less) school census data is available. The census usually provides the most up-to-date role of preschool children. Contact each local school district to find out if they have a census, how recent it is, and the feasibility of your agency using a copy of the census for children 5 years and younger to conduct the project. When a final decision is made as to the area in which the project will be conducted, a copy of the census must be obtained. The form in which the census is recorded and stored varies. Some schools are willing to give you a computer print out. For others it may be necessary to have a volunteer copy the information from index cards.

Obviously when inquiring about the census, it is essential to explain the project and try to

solicit the school district's cooperation, perhaps in even cosponsoring the project. The more recent the census and the more cooperative the school district, the higher priority the area is given.

Time: Day 58-50

Resources: Volunteer to copy census (if needed).

3. Determine the availability of manpower to assist in conducting the project. Contact community leaders such as ministers and school principals to solicit their advice and support. If the coordinator is unaware of possible volunteers, he asks the leaders to assist him in locating volunteers. Service clubs are an excellent source of help. Groups which are available during the day and are not identified with controversial issues are optimal such as the PTA, Junior Women's Club, Senior Citizens, and Church organizations.

    Certain agencies may also be willing to contribute staff time. The Agency Needs Assessment Cover Letter had asked agencies to call the coordinator if they could offer any assistance. High priority is given to areas which have an ample supply of volunteer or agency help.

Time: Day 58-50

Resources: Agency Needs Assessment Cover Letters; Names of community leaders.

4. Determine the feasibility of conducting a screen based on the information gathered above regarding the availability of a) follow-up services, b) recent census data, and c) reliable manpower. Without any of these resources, the likelihood of success is greatly reduced.

Time: Day 46

STEP 3

Objective: Decide where or the geographic area in which to conduct the screen.

Personnel: Coordinator and other agency personnel.

Tasks:

1. Consider screening so-called natural geographic areas such as townships or elementary school areas. Avoid screening two towns with intense rivalries during the same screen. Avoid screening areas together that are separated by a natural barrier such as a mountain, making travel difficult for one of the groups involved. Facilities must be available which are centrally located or convenient for most people in the area to go to.
2. Based on the above and the information collected in STEP 2, i.e., the availability of a) follow-up services, b) census data, and c) manpower, rate each geographic area. Select the area which rates highest on the three criteria.

Time: Day 46

Resources: Census data,
Information regarding feasibility of follow-up services,
Information regarding availability of reliable manpower.

STEP 4

Objective: Decide when is the optimal time to conduct the screen.

Personnel: Coordinator

Tasks:

1. Determine which time of the year the manpower as well as a screening site is more readily available. Talk with the community leaders and the potential volunteer groups.
2. Determine the time of year when you are likely to get the largest turnout of children and parents at the screen. In most communities summer is vacation time and in the harsh winter months sickness is more prevalent and transportion can be a problem.
3. Determine if there is any time of the year when follow-up service openings are more likely to be available. For example, many Head Start programs start up in fall and terminate in the spring. The Agency Needs Assessment (Appendix B) provides information concerning when services are available.
4. Based on the information collected above decide when is the optimal time to conduct the screen.

Time: Day 46

Resources: Agency Needs Assessment

STEP 5

Objective: Decide approximately how many children are to be screened and the number of screening days necessary.

Personnel: Coordinator

Task: From the census data the coordinator has a rough estimate of the number of children in a given area. It is recommended that the screen include 100-300 children. The rule of thumb is that 1 screener can test 3 children per hour. Thus, in a 7 hour day each screener can test 21 children. To screen 100 children each day you need 5 screeners working approximately 7 hours.

Formula: # of screeners x 3 x # of hours = # of children screened per day

Highly skilled screeners can test 4 children per hour.

The number of children screened per day is limited by the availability of screeners and space. Of course, there is the practical consideration of dealing with large numbers of children and parents, too.

Time: Day 45

Resources: Census data estimate

STEP 6

Objective: 1. Obtain a clear, thorough understanding of remaining steps of the process and the function of each task group.

2. Decide the exact dates of the screen and determine a time line for remaining steps leading to the screen.

Personnel: Coordinator

Tasks: 1. Prior to meeting with and organizing the volunteers (STEP 7), the coordinator must study all the steps leading up to the screen as well as the screening process itself, so that (s)he is totally familiar with the function of each task group. The coordinator must read and study the remaining steps in the manual. (S)he must think through how the process will work in this specific instance. What variations may be necessary? What problems should be anticipated which haven't been discussed in the manual?

2. The coordinator must specify the exact dates for the screening and then work backwards to devise a time line for when each group must undertake and complete its task. The exact dates are to be recorded on the Early Identification Time Table (Figure 3).

Time: Day 45

Resources: Early Identification Time Table and this manual

STEP 7

Objective: Organize community volunteers into Task Groups

Personnel: Coordinator

Tasks: 1. Continue to seek the support of community leaders and their assistance in locating and soliciting the help of volunteer groups. This may require becoming

acquainted with community leaders (lots of cups of coffee) to gain their confidence.

2. Set up a meeting of potential volunteers and if possible community leaders to sell them on the idea of early identification. It should be an arousing, motivating meeting. Use multi-media if available such as films or slide presentations. Tell them of the urgent need for early identification. Point out case examples of how early identification can lead to early intervention to facilitate maximum development of handicapped children. Show them how they can help by helping to find a screening site, stuffing envelopes or even screening children. Pass out a prepared sign-up list for each Task Group indicating the number of volunteers you need for that group, what the task group is to do, and when it needs to be done. (See Appendix C for a sample Sign-Up Sheet.) Encourage volunteers to sign up.
3. Determine if any of the volunteers can serve as Task Group chairpersons. It is particularly helpful to find a capable person who is willing to chair the Mailing and Response Task Group. Community leaders may be able to direct you to volunteers who may be possible group leaders.
4. Indicate that you will meet with or contact by telephone each Task Group to provide clear direction and on-going supervision.

Time: Day 35

Resources: Sign up Sheets

Multi Media film and equipment (if desired)

Meeting place

STEP 8 - Site Task Group

Objective: Locate a suitable screening site

Personnel: 2 volunteers and coordinator

Tasks:

1. Volunteers meet with the coordinator who will give them copies of the Site Criteria Forms (Appendix F) and explain the criteria for selecting a site and demonstrate how to fill out the form. The site criteria are: a) The site must be centrally located or easily accessible by car with ample parking space. b) A reception area (approximate size 9' x 12') with space for a receptionist, chairs for waiting children and parents, and a babysitting area. The reception area should be separate from the screening area. c) A screening area that can be divided into screening booths (approximate size of each screening booth 7' x 9') with room for a table, 3 chairs and an area for gross motor activities. Partitions are necessary to screen each area to reduce distractions. If partitions are not available at the site, makeshift partitions such as used sheets can be obtained and hung from clothes lines. d) An interpretation area (approximate size 5' x 5') with space for 3 chairs and a table.

e) Tables and chairs. f) Available at desired times. (Refer to sample floor plan Appendix E).

2. The volunteers identify possible sites (churches, schools, fire halls, etc.) to which people will feel comfortable bringing their children. They visit each site and fill out the Site Criteria Form for those sites which appear to be possibilities and check off those which do not meet the criteria. The volunteers should take a tape measure to obtain an accurate measure of the exact size of the facilities and draw a sketch of the space on the reverse side of the form. The volunteers should locate 3 possible sites.
3. The volunteers return the forms to the coordinator and make their recommendations.
4. The coordinator visits each potential site and makes final arrangements for its use. The coordinator must not rely solely on the volunteers' recommendations but must see each site first-hand.

Time: Day 28

Resources: Site Criteria Form; tape measure

STEP 9 - Preparing and mailing of letters

Objective: 1. To prepare information about the screen and appointment times for mailing to parents of each child listed in the census, and

b. To mail the letters to the parents.

Personnel: Coordinator and 1 volunteer per 33 children on mailing list

Tasks: 1. Prepare information:

1-1 From the census data record the child's name and parent's name, address and telephone number on to the Master Data Record (Appendix F).

1-2 Using the names from the Master Data Record, the Master Appointment Schedule is filled out in pencil (Appendix G). As a rule of thumb, schedule 4 children per screener per hour. (Even though a screener can usually only test 3 children per hour, the "no show" rate is typically about 25%.) Thus, each child on the census is scheduled randomly for an appointment which is recorded on the Master Appointment Schedule. Each appointment time is also recorded on the Master Data Record in the first column.

1-3 Address envelopes; one to each family.

1-4 The coordinator must write a letter to parents (see Appendix H for a sample Parent Letter) explaining the purpose of the screen and make duplicate copies so that one letter may be sent to each family. The letter, if possible, should be typed on official school district stationery. This will give the project more legitimation.

1-5 Using the information from the Master Appointment Schedule, volunteers fill in the time and date of appointment on the Parent Letter.

1-6 The coordinator must desin and duplicate a self addressed reply postcard (see Appendix I for suggested forms). It is recommended that return postage also be affixed to the postcard. The postcard is a quick easy means of enabling the parents to respond to the request to bring their child to the screen.

1-7 The Parent Letters must be folded and stuffed in the appropriate envelope along with a copy of the reply card. If there is more than one child in a family, insert one reply card for each child, but only one Parent Letter per family.

1-8 Stamp the envelopes and mail.

Time: Days 20-18

Resources: Master Data Record

Master Appointment Schedule

Parent Letter

Envelopes

Reply Postcards

Stamps

Duplication service

Typewriter

STEP 10 - Recording replies and responding to questions

Objective: To record parent replies and make necessary telephone calls to parents.

Personnel: 2 volunteers

Tasks:

1. Record parent replies and make necessary telephone calls to answer parent questions or initiate further contact with the parent who fails to respond with the reply card.

1-1 After the letters have been sent out, each day or two the chairman of this committee picks up the reply cards.

1-1-1 Records responses on Master Record Form

1-1-2 Record telephone numbers on Master Record Form

1-1-3 Check address with the one on Master Record From

1-1-4 Check child's birthdate with the one on the Master Record Form.

1-2 Give all cards requesting more information, transportation or another time to a volunteer who has the Master Appointment Schedule and Trainsportation Cards (see Appendix J).

1-2-1 This volunteer should make the requested telephone calls as soon as possible, using the Telephone Script (see Appendix M) and the Possible Questions and Answers (see Appendix L). This

script is meant as a suggestion to aid the telephoners. These ideas should be put in each person's own words and merely be used as a guide to answer questions. Record these questions at the bottom of each reply card.

1-2-1-1 If the call is to arrange transportation, record this on the transportation form recording also the correct address, directions to the home, and time for pick up allowing time to reach the screen site in time for the appointment. Record this also on the bottom of the form.

1-2-1-2 If the call is to arrange for a different time: Using the master schedule, arrange a suitable time and record it on both the reply card and the Master Schedule.

1-3 Return the reply cards to the chairperson. The chairman records the results of the calls on the Master Data Record.

STEP 11 - Advertising Task Group

Objective: To make the public aware that a screen is being held and to prompt all parents of preschoolers to bring their children to the screen.

Personnel: 2-3 volunteers

Tasks:

1. Advertising should be released at the same time the letters are sent out and also immediately prior to screening (Days 3-6). Suggested free media include: public services articles in local newspapers, public service announcements on local radio and TV stations, guest speaker on local TV or radio program, fliers sent home with elementary school children, church and service organization announcements, and posters placed in stores, laundromats, churches, schools, civic centers, etc. Paid newspaper ads are also very effective.
2. Check with each media to find out the format they require for releasing information and how long before the release they need the information. Usually the information must be received 1-2 weeks before release date.
3. The contents of the release should include what screening is (Free Developmental Check-Up), who screening is for (All children ages 6 mos - 5 years in "such and such" an area), when the screen is to be held (dates and times), where the screen is

to be held (site location) and what parents should do if they want to bring their child (telephone number to call). (See Appendix M)

4. Suggestions for use of each media: newspaper articles should be written in newspaper style with detail. Some of the volunteer groups or persons might be mentioned; radio and T.V. announcements must be succinct including skeleton details only; fliers sent home from school can include the details of what a screen is and why it is important; and releases to churches and service organizations should be similar to radio release so that it can be read to a meeting. More detail can be added as a supplement for those who want more information. Encourage pastors to read from their pulpits and include the information in the church bulletins.

Time: Days 20-18 (same time as Parent Letters are sent out) and Days 6-3

Resources: Names of local media
Poster board and lettering
Typewriter

STEP 12 - Train screeners

Objective: To train volunteers to reliably administer the Denver Developmental Screening Test.

Personnel: Coordinator and volunteers

Tasks: 1. The coordinator should be well-trained in administration and interpretation of the DDST or should

have access to a professional with those qualifications.

2. The coordinator (or professional) using the DDST manual and training films* should instruct the volunteers in the rationale for the screening, the techniques of screening, and the actual administration of the DDST. The coordinator should be sure to cover each item on the screener's checklist. (See Appendix N) for conducting the examination.
3. Approximately one week before the screening, each volunteer should be observed screening at least two children of different ages, so that the coordinator may answer any questions, provide feedback, and model, if necessary. Children may be the screener's own, or those in a cooperating preschool, in short, any that can be obtained.

Time: Day 10

Resources: DDST Training films

DDST Kits and scoring sheets

Screeners' checklists

STEP 13 - Telephoning nonrespondents

Objective: To make telephone calls to parents who did not return appointment cards.

Personnel: 1 volunteer per 15-20 telephone calls

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*Available from: Ladora Project and Publishing Foundation, Inc.
East 51st Avenue and Lincoln
Denver, Colorado 80216

Tasks:

1-1 When the deadline for all cards to be returned has passed, the telephone chairperson contacts the coordinator and the decision whether to call all those who have not responded is made.

1-1-1 Typically 95% of all who confirm appointments by card or telephone calls actually keep their appointments.

1-1-2 Less than 5% who do not confirm their appointments either by card or telephone keep their appointments.

1-2 If it is decided to call al of those who have not responded, the chairperson of this committee should arrange for persons to make these calls. Each person should be asked to make no more than about 15-20 calls and a date for completion should be Day 3.

1-2-1 The chairperson and coordinator should train these people to use the Telephone Script (see Appendix K) and the possible Questions and Answers (see Appendix L). This is given only as a guide.

1-2-2 Each caller will be given sheets of the Master Data Record and will call those on the sheets who have not returned reply cards.

1-2-2-1 Training should be given in filling out the Master Data Record.

1-2-2-2 Help should also be given in ways to determine telephone numbers if they are not in the book.

1-2-2-3 Calls should be made at various times during the day and evening since some people work.

1-2-2-4 Callers should record correct phone numbers in the Master Data Record.

1-3 Callers make assigned calls by designated date and record information and telephone numbers on Master Data Record.

1-3-1 If a different appointment time is needed; the caller should assign a convenient time and record this both on the Master Data Record and a separate sheet of paper to be put on the Master Appointment Schedule. The incidence of appointment conflicts has proven to be so low that these people can be worked into the schedule. Therefore, it is not necessary to have the Master Schedule when making these changes.

1-3-2 Record transportation needs on the transportation cards for the transportation committee.

1-4 Return all Master Data Records to the chairman or coordinator with appointment changes and transportation needs. Make changes in Master Appointment Schedule.

Time: Days 6-3

Resources: Master Data Record
Master Appointment Schedule
Transportation Cards
Telephones
Telephone Scripts
Possible Questions and Answers

STEP 14 - Denver Score Sheet Task Group

Objective: To prepare Denver Score Sheets for each child prior to screen

Personnel: 1 volunteer per 50 children

Task: Using the information on the Master Date Record

1. Prepare a Denver Score Sheet for each child by writing his name, birthdate, and parents name at top of sheet. Then using a ruler draw in the age line (child's current age) according to the directions in the Denver manual. (See Appendix O for a sample Score Sheet.)
2. Arrange score sheet[illegible] alphabetical order.

Time: Day 5

Resources: Master Data Record
Denver Scoring Sheets
Sample Age Chart
Ruler

STEP 15 - Site Preparation Task Group

Objective: To prepare the site for the screen so that the area needed by each worker will be ready and all necessary materials will be available.

Personnel: 2-3 volunteers and coordinator

Tasks:

1. Outside the building put up posters or signs identifying the building as the site for the screen, also put up the signs leading people into the reception room, if necessary.
2. In the reception-babysitting area, arrange for a desk or table for the receptionist. This should be in an area of the reception room which people will come to upon entering the room but should not cause a congested traffic pattern. See reception section for a list of materials required by the receptionist (the chairperson of this committee is responsible for these things.) Chairs should be provided for those waiting. A toy corner should be set up with toys and books donated for this area. A coat rack is also suggested during the cold months. Check bathroom facilities for cleanliness and supplies.
3. Screening area: One area per screener is needed. Partition these areas, if they are not already. Moveable screens can be used or sheets hung on clothes lines are equally effective. A table and three chairs are needed within each screening booth, along with an area for gross motor testing. Each screener will need a test kit, Denver Manual, extra raisins, paper and pencils. Colorful posters

or pictures can be hung to make this area more appealing for children and adults.

4. Interpretation area: one area per interpreter is needed. These areas should be partitioned and provide as much privacy as possible. A table and three chairs are needed. The interpreter will also need a Denver Manual, and a form to record the names of those persons requiring further services and appointment times if follow-up appointments are to be made.

5. Suggestions: the coordinator must supervise the site preparation. An extra supply of items such as sharpened pencils, pens, rulers, staples, paper clips, paper, tape (scotch and masking), markers and scissors is helpful. An area where volunteers can go to have coffee and a snack is helpful but not a necessity.

Time: Day 1

Resources: Site

Tables and chairs

Posters

Partitions

Denver Scoring Sheets and Manuals

STEP 16 - Receptionist Task Group

Objective: To greet parents, provide forms and facilitate entire screening process

Personnel: 1 receptionist present at all times during screen.

Tasks:

1. Check reception table to be sure all materials are there:
   - -- Denver Score Sheets in alphabetical order
   - -- Returned appointment cards in alphabetical order
   - -- Parent Consent Forms for parent to sign (see Appendix P)
   - -- Master Appointment Schedule
   - -- Blank Denver Score Sheets
   - -- Pen, pencils, paper, staples
2. Check Master Appointment Schedule and put out cards for persons scheduled for the next four appointments. If an appointment card is not found, prepare one.
3. When the parent and child arrive, the receptionist greets them and asks their name and checks them off on the Master Appointment Schedule and suggests that the child might like to go to the toy corner for a few minutes until the screener is ready while the parent may be seated.
4. Take the Denver Score Sheet and check the child's name and birthdate. Put this in a pile so that people will be taken on a first-come first-serve basis. If there is no Denver Score Sheet for a child, make one, calculating the age. Take the Appointment Card and check all information contained in it, making sure it is accurate and complete. Place in a pile. These will later be stapled to the completed Denver Score Sheets.

5. After the child has been screened and the mother and child return to the reception area, ask the parent to sign the consent form, and then ask the parent to be seated giving assurance that someone will interpret the results shortly.
6. Staple the appointment card to the front upper left hand corner of the Denver Score Sheet and the consent form to the back in the same position. Place this in the proper place for the interpreter to pick up.
7. In addition to the above duties the receptionist should be alert for any situations requiring his or her aid. The babysitter or person providing transportation may be asked to fill in for the receptionist if it is necessary to be away from the desk for a few moments.

Time: Screening days

Resources: Denver Score Sheets
Master Appointment Schedule
Consent Forms
Sample Age Chart
Appointment Cards
Pen, pencils, paper and staples
Table and chairs

STEP 17 - Transportation and Babysitting Task Group

Objective: To provide transportation for parents and children who request it, and to babysit for children while their siblings are being screened or their parents are given the results of the screen.

Personnel: 1 babysitter present at all times during screening. Drivers available at requested times.

Tasks:

1. Babysitter: see that toys are available in baby-sitting area, that the babysitting area is safe, and supervise and play with children (usually 2-3) during the screening.
2. Transportation: the drivers must provide their own car and should be familiar with the geographic area. They should check their insurance company to be sure that passengers are covered. A transportation schedule must be devised based on the information from the Transportation Cards. The driver then picks up and returns parents and children according to the schedule.

Time: Screening days

Resources: Toys

Car and insurance coverage

Transportation Cards

STEP 18 - Conducting the screening

Objective: To screen each child using the DDST

Personnel: Volunteers trained in administering the DDST

Tasks:

1. Before screening any child, each screener must be sure that their screening area, with a table and chairs, is partitioned off and their DDST Kit is complete.
2. When ready for the first child, the screener should walk out to the reception area, and obtain from the receptionist the DDST scoring sheet for the "on-deck" child. The screener will then announce the name of the parent whose child is to be screened, and escort them to the screening area.
3. After sitting down, the screener will begin by speaking to the parent confirming the child's birthdate and scoring personal-social items in order to allow the child to adapt to the situation and screener.
4. The screener will then begin the administration of the DDST, being careful to include all appropriate test items, as well as follow all the procedural items on the screener's checklist.
5. When the screening is over, the screener should escort the parent(s) and child back to the reception area, give the child's DDST scoring sheet to the receptionist, and obtain from the receptionist the DDST scoring sheet for the next child.

Time: Day of screening

Resources: DDST Kits

Table and Chairs

DDST scoring sheets with age/misc. filled in

STEP 19 - Interpreting screen results

Objective: To discuss and interpret the results of the child's screening to the parents.

Personnel: Coordinator and one volunteer

Tasks:

1. The coordinator will be responsible for interpreting the screening results to the parents of any child who fails to pass, or performed questionably on the DDST. A volunteer who has been well-trained in the administration of the DDST will interpret the results to parents whose children have passed the screening.
2. Interpreters will check the tray of completed DDST's on the receptionist's desk. The coordinator will take the first scoring sheet from the bottom which reports a fail or questionable performance for any child. The volunteer, also starting from the bottom of the stack, will take the first "passing" scoring sheet. Both interpreters will then look over the sheets before calling on the parents from the reception area.
3. Each interpreter will then escort the parent(s) and child to the interpretation area and ask them two questions (see Appendix 2). For the volunteer, it will only be necessary to point out to the parent the purposes and limitations of the screening, i.e., that it is not an intelligence test, and then tell the parent what the child did or expected, for that particular age.

The coordinator, however, must be more tactful in reporting to the parent(s) as "bad news" in their case is being delivered. The coordinator should stress the rationale behind the screening as well as the limitations. In telling the parents the areas or particular items that the child failed, the coordinator should be sure to point out the child's strengths. The parents should be asked if the child's behavior/performance on that particular day was typical, and told that the child may have performed very differently on another day, in another place, and with another screener. Telling the parent that a screen is designed to "over-refer" and the child's performance at this point in time is nothing to be overly concerned about, the coordinator should then inform the parents of the rescreening date (if one is planned), or attempt to make an appointment with the parent and child for a rescreening at home, one month later.

4. Upon conclusion of the interpretation, the interpreters should thank the parents for bringing their children to the screen, and escort them back to the reception area. The child's scoring sheet should then be placed in the completed interpretations tray with a record kept of those needing to be rescreened.

Time: Day of screening

Resources: Completed DDST scoring sheet

Table and 3 chairs

STEP 20

Objective: To record and tabulate the results of the screening

Personnel: Volunteers

Tasks:

1. Using the Master Data Record, a "1" or "2" for "pass" or "rescreen" respectively, should be recorded under the appropriate column for each child who was screened.
2. The total number of "passes" out of the total number screened, should then be tabulated. The names of those children whose performance indicated a need for rescreening and whose parents agreed to a home visit one month later, should be recorded on the last column of the Master Data Record. All other children needing rescreening should then be scheduled for a time a month later, on a form similar to the Master Appointment Schedule, using the task guidelines of Step 9.

Time: 1 day after screening

Resources: Master Data Record

Scored DDST Forms

Duplicate Master Appointment Schedule

STEP 21 - Rescreening

Objective: To rescreen those children who failed or performed questionably on the DDST

Personnel: Coordinator and volunteers

Tasks:

1. Those children who had failed, or performed questionably, on the DDST upon first administration, should be rescreened approximately one month later.
2. If a child is being rescreened through a home visit, the screener should confirm the appointment two days before the earlier agreed appointment was to take place. When in the home, the screener should be sure that major distractions to the child are removed, e.g., televisions and radios are shut off, siblings asked to leave, etc.
3. If a general rescreening is taking place, the coordinator should organize its occurrence along the task guidelines of steps through .
4. The performance of those children being rescreened will then be recorded as "pass" or "fail" on the Master Data Record, and the total "passes" and "fails" of the rescreened will be tabulated.

Time: One month after the initial screening

Resources: DDST Kits and scoring sheets

Master Record Form

Duplicate Master Appointment Schedule

Automobile

Telephone

Tables and chairs

STEP 22 - Making referrals

Objective: To refer parents to agencies which can assess and/or provide services to their children

Personnel: Coordinator

Tasks:

1. Based on the replies from agencies contacted prior to the screenings, the coordinator should evaluate each child who failed their rescreening on the DDST and determine which agencies would be best suited to assess and possibly provide placement for each child.
2. The coordinator then has the choice of contacting the agency by letter (see Appendix R) and informing them of the child(ren) who may be in need of their services, or informing the parents by letter (see Appendix S) of the agencies they may contact.
3. If the coordinator chooses to give the parents the option of initiating contact with an agency, the coordinator should notify the agency by letter (see Appendix T) of the possibility of that particular child's parents contacting them.

Time: 1-7 days after rescreening

Resources: Agency letter "A"
Parental Letter
Agency letter "B"
Envelopes

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APPENDICES

APPENDIX A

Screening Instruments

The Denver Prescreening Developmental Questionnaire (PDQ)

The PDQ, developed by Frankenburg, et al., (1976) allows parents to prescreen the development of their children through carefully worded questions designed to ascertain their children's current observable developmental landmarks. The questions cover a range of ages from three months to six years, and were created by modifying items from the Denver Developmental Screening Test (DDST) (Frankenburg and Dodd, 1967) into questions answerable by a parent. Parents typically need answer only 10 age appropriate questions, taking only about five minutes of their time. Being economical also, the PDQ is thus a quick first stage developmental screening procedure that lends itself to the mass screening of all children, and identifies those children who require a more thorough screening with the DDST.

Guide to Normal Milestones of Development

This "wheel" device, was originally developed by Haynes (1967), for use by nurses dealing with infants and newborn children of ages one to thirty-six months. By turning the wheel basic reflex patterns are indicated to be present, absent, evolving or deminishing for the particular age of interest, as well as the major milestones of development for that age. In addition, on the back of the wheel are summarized the conditions which can indicate that referral to medical attention is warranted. As the basis of a primary screening system, it is hoped that the facility with which the developmental wheel can be dialed forward and backward, to refer to preceding and following stages, will help the nurse focus upon the overall rate of development rather than the individual stages of any one factor.

Rapid Developmental Screening Checklist

This checklist was developed by the Committee on Children with Handicaps at the New York Chapter of the American Academy of Pediatrics (Giannini, 1972). This one-page instrument has some brief instructions at the top and is designed to be used by a physician or aide. The checklist is very simple and straightforward, and consists of 40 items covering the age range from one month to five years of age. It has the potential to serve as a primary stage screening instrument for a widespread canvasing of a large population in a massive screening and assessment program.

The CCD Developmental Progress Scale

This scale, developed by Boyd (1969), is designed for administration by a properly trained paraprofessional. It consists of 150 items, some immediately and directly observable and measurable, and others ascertained through parent interviews. The age range for the scale is birth to eight years, and it enables the user to see at a glance comparative levels of functioning in the areas of motor skills, communication-interpersonal skills, and self-sufficiency skills. At the same time, the scale identifies those skills below the general level of the child's functioning which, for one reason or another, may not yet have emerged and should therefore receive special attention. The scale is administered casually with a few simple objects such as paper and pencil, a rattle, a tennis ball, a small bottle, candies, coins and some blocks.

The Developmental Screening Inventory

This developmental screening instrument, created by Knoblock, Pasamanick and Sherard (reported by haynes, 1967, pp. 77-78) is of use

for children from 4 weeks to 18 months of age. The instrument examines five areas of development--adaptive, gross motor, fine motor, language and personal-social--and is administered by a paraprofessional by asking some questions of parents, observing the infant's behavior, and recording this information systematically. This screening inventory is of value for serial observation in well-baby supervision as well as for diagnostic problems referred for evaluation.

APPENDIX B

Agency Needs Assessment Cover Letter

Dear Sir or Madam:

The (name of agency) has the responsibility of identifying all handicapped preschoolers in this area. A community wide volunteer assisted effort designed to screen all children, 6 months to 6 years of age will be the primary means of locating the target population. Of course, referrals from parents, physicians, and human service workers are another important source. To determine the feasibility of conducting a comprehensive early identification project; it is essential to know the availability of services for children who are identified as handicapped children and see that they receive the best appropriate service available.

The attached assessment is designed to provide an accurate picture of the services your agency offers handicapped children (ages 6 months-6 years) and their families.

Please take a few minutes to complete the brief assessment and return it no later than _____.

If your agency is interested in learning more about the early identification project or has staff members who may wish to volunteer a few hours of their time in this community effort, please contact ( ).

Thank you for your cooperation.

Agency Assessment Form

The purpose of the assessment is to determine if your agency provides services to handicapped children and/or their families, and if so what is the nature of the service offered.

Name: _____ Position: _____

Agency: _____ Date: _____

1. yes no Does your agency currently offer or does it intend to offer in the near future, any services to handicapped children (age 6 months-6 years).

2. yes no Does your agency currently offer or does it intend to offer in the near future, any services to families of handicapped children (age 6 months-6 years).

3. Please describe the goal of the service your agency provides to the target population.

4. What is the age range of the target population?

5. What type(s) of handicapping conditions do children have?

6. Describe the type of service your agency provides to the target population.

7. What agency staff usually provide the services, e.g., social workers, psychologists, special education teachers, nurses, etc.

8. How many handicapped children (age 6 months-6 years) or families does your agency usually serve.

9. How many openings might your agency have in (month following screen)?

10. When do you anticipate or when do you typically have openings available?

APPENDIX C

Sample Sign up Sheet

Site Task Group

Purpose: To find an appropriate school, church or other facility to hold the screen.

Number of volunteers needed: 2

When to be done: May 2

1. _____

2. _____

APPENDIX D

Site Criteria Form

Directions to worker: After meeting with the coordinator, make appointments to see a number of potential sites. Use this form when visiting each site. Fill it out as completely as possible. Bring a tape measure and draw a sketch of the space on the back of this form. When all potential sites have been visited, meet again with the coordinator to discuss your findings.

Site _____ _____

Person in charge _____ Telephone # _____

Dates of Screen _____ hours _____

Location: _____

_____

Is this site wasy to get to? _____

Is it centrally located for our screening area?

Is parking available? _____ Is it free? _____

Are there any reasons why people might be against bringing their child to this site?

(name them) _____

_____

Check below if this site meets the following criteria.

_____ 1. Reception area (9' x 12' min) room for receptionists table, chairs and babysitting area. Some what removed from screening area.

_____ 2. Screening area--1 per screener per shift (7' x 9' min) room for 3 chairs, table and child to perform grossmotor activities.

_____ 3. Interpretation area--1 per interpreter per shift (5' x 5' min) room for 3 chairs, table.

_____ 4. Partitions are available or make shift partitions can be fabricated.

_____ 5. Are the following materials available? tables: 1 per screener, 1 per interpreter, 1 for receptionist.

chairs: 3 per screener, 3 per interpreter, 7 for reception area.

APPENDIX E

Screening Area Floor Plan and Layout

Area A . . . . Babysitting

Area B . . . . Reception

Areas 1-10 . . . . Screening Carrells (includes table, chairs, gross motor area)

- - - - - } partitions/screens

APPENDIX F

Master Data Record

Place C in this column when appointment is confirmed circle C if appointment kept	Child's name and birthdate	Parent's name address and telephone number	Appointment card returned 1. appointment confirmed. 2. transportation needed. 3. another time. 4. more information. 5. will not come	Telephone call made 1. made appointment. 2. transportation arrange. 3. will not come	Screen 1. pass 2. re-screen	Follow up note appt time and disposition of case.

Date: _____

	1*	2	3	4	5
9:00**					
9:15					
9:30					
9:45					
10:00					
10:15					
10:30					
10:45					

* Columns = number of screeners
** Times will be times selected for your screen
four appointments/screener/hour

APPENDIX H

THE PENNSYLVANIA STATE UNIVERSITY
Division of Special Education
304 CEDAR
UNIVERSITY PARK, PENNSYLVANIA 16802

Division of Special Education
— Education of Exceptional Children
— Speech Pathology and Audiology

Area Code 814
865-1183

Sample Parent Letter

Dear Parent:

As a parent you are no doubt concerned about your child's development or readiness for school. With this in mind, The _____ _____ is offering parents of preschool children ages six months to six years in the _____ area an opportunity to have their child's development checked. The check-up is free and takes about 30 minutes.

For your convenience a check-up appointment has been scheduled for your preschool child on _____ at _____. The check-up will be provided. If you need transportation, it will be available by request.

So that we can better serve you, also fill out the enclosed Appointment Form by _____.

If you have any questions or if you do not have a telephone call _____ between _____ for assistance.

We are looking forward to seeing you and your child on _____ at _____.

Sincerely,

AN EQUAL OPPORTUNITY UNIVERSITY

APPENDIX I

Appointment Form

There are two types of appointment cards that may be used (see next page). The first gives no option to the parent to say no. The parent who may wish to say no typically does not return the card. The option is then left to call these persons and convince them to bring their child to the screen. This does take personnel time for calling, however, it has been found that persons who do not return the card confirming the appointment, or who are called to confirm the appointment rarely come to the screen. In most cases these follow up telephone calls will greatly increase the number of children screened. The alternate form allows the parent to say no and this precludes any follow up call. The decision of which form to use is one that the coordinator and the reply chairperson will want to make after considering such things as local factors, persons available to make telephone calls and relative numbers of persons having telephones in your area.

Appointment Card

Please fill out this card and return it as soon as possible.

Child's Name _____ Birth Date _____

Parent's Name _____ Telephone _____

Address _____

Check (✓) the correct statement(s).

_____ Yes, I will bring my child to the screening at the appointment time.

_____ Yes, I would like to bring my child but please call me to arrnage another time.

_____ Yes, I will bring my child. I need transportation. Call me to arrange for it.

_____ Please call me. I would like more information.

Appointment Card

Please fill out this card and return it as soon as possible.

Child's Name _____ Birth Date _____

Parent's Name _____ Telephone _____

Address _____

Check (✓) the correct statement(s).

_____ Yes, I will bring my child to the screening at the appointment time.

_____ Yes, I would like to bring my child but please call me to arrange another time.

_____ Yes, I will bring my child. I need transportation. Call me to arrange for it.

_____ Please call me. I would like more information

_____ No I will not bring my child to the screen.

APPENDIX J

TRANSPORTATION CARD

Child's Name _____ Appt: _____

Time: _____

Father's Name _____

Phone _____ Time to Pick Up _____

Address _____

_____

Directions to address:

APPENDIX K

Telephone Script

Directions

This is a suggested script which is intended to give guidance in what to say when making telephone calls. Feel free to use your own telephone style and expressions, being certain, however, to convey the correct information. Please record on the back side of each page any questions or problems which are not covered in this script or any changes you think should be made in the script.

There are four typical reasons to call parents:

1. No return of forms;
2. Another appointment time needed;
3. Transportation needed;
4. More information desired.

For each of these reasons, possible parent questions are given with suggested answers. The proper form upon which to record the information received from the parent is indicated in the script.

No Return of Forms

Ask parent if she wants an appointment

Hello, this is (Name) calling for the local school district. May I speak to Mrs. _____? or is (child's name)'s mother there? (Always ask to speak to the mother. If she is not home, call back.) We got your child's name from the school. I am calling about a free developmental check which is being offered to all children under age six in this area. This checkup is very important. It's like a medical checkup. The purpose is to see if your child does most things you would expect him/her to do at his age--like how many blocks can he/she stack or can he/she follow directions. This checkup may prevent later problems in school. The checkups are being done at (location) on (Dates). It takes about a half hour. Can we arrange an appointment for (child's name)? (There are three likely responses the mother may give.

1. Mother says, "Yes"

We have (times) available. Will any of these be convenient? (Record appointment time on Master Appointment Schedule and ask parent if she can provide her own transportation. If not, fill out a Transportation Card and indicate at what time someone will pick them up.)

Do you know anyone else with young children, I should contact--friends, relatives, or neighbors? (If yes, get parents' name, address, and phone number and child's name). We'll see you on (day) at (time) at (location).

2. Mother says, "No"

Would you like someone to come to your home and check your child's development? (If parent agrees, arrange a time and find out directions to the home. Put all this information on a Transportation Card and write HOME VISIT on the card. If parent does not want a home visit, tell parent that if she changes her mind, she can just come to the checkup or call (telephone number).

3. Mother says, "I need more information"

(Try to answer parent's questions as best you can. Use the Questions and Answers sheet. After answering the parent's questions, again ask her if we can arrange an appointment for her child. If you are unable to satisfactorily answer the parent's question, tell her you will have someone else who can answer her question call her. Give the parent's name and her concern to your coordinator or supervisor.)

Another Appointment Time Needed

Hello, this is (name) calling for the local school district. May I speak to Mrs. _____ or is (child's name) 's mother there? (Always ask to speak to the mother. Call back if she is not home.) I'm calling about the free developmental check which is being offered to all children under age six in this area. You indicated on the card you returned that you wanted a different appointment time. Would (times) be convenient? (Record appointment time on Master Appointment Schedule.)

Do you know anyone else with young children I should contact--friends, relatives or neighbors? Someone will pick you up on (date) at (time) at (location).

Need Transportation

Hello, this is (name) calling for the local school district. May I speak to Mrs. _____ or is (child's name)'s mother there? (Always ask to speak to the mother. Call back if she is not there.) I am calling about the free developmental checkup which is being offered to children under age six in this area. You indicated on the card you returned you wanted to bring your child on (date) at (time) but you need transportation. I can arrange for someone to pick you up. (Fill out Transportation card.)

Do you know anyone else with young children I should contact--friends, relatives or neighbors? Someone will pick you up on (date) at (time).

Need More Information

Hello, this is _____ calling for the local school district. May I speak to Mrs. _____ or is (child's name)'s mother there? I am calling about the free developmental checkup which is being offered to children under age six in this area. You indicated on the card you returned that you wanted more information about the checkup. What would you like to know about it? (Answer parent's questions as best you can. Use Questions and Answers sheet. After answering parent's questions, ask her if we can arrange an appointment for her child and see page 1 and 2 for possible parent responses. If you are unable to satisfactorily answer parent's questions, tell her that you will have someone call her who can give her answers. Give the parent's name and concern to your supervisor or coordinator.)

APPENDIX L

Possible Questions and Answers

Questions	Answers
1. Why did you send this letter to me? There is nothing wrong with my child.	Letters were sent to all parents of preschool children in _____. The _____ is interested in checking all children to find out how well they are developing.
2. Can someone else bring my child?	Yes, we will send you a consent form which you should sign and send with your child to the checkup.
3. What kind of a test will my child be given?	The Denver Developmental Screening Test which includes a series of simple activities to find out how well each child is developing. Four areas are checked: a) motor development, b) problem solving, c) communication, and d) self help.
4. Will I be given the results of the checkup?	Yes, right after the checkup.
5. Who else will be given the results?	The results are confidential and will be given only to the CIU and the school district. You may request that the school district send the results to anyone that you choose.
6. What will happen if my child doesn't do well on this test?	There will be a follow up in your home. One checkup is not conclusive; therefore, a second will be done.
7. What if my child doesn't do well on the second checkup?	
8. Why is this being done?	To determine children who might have a problem that would interfere with future progress in school and also in order to plan better programs to help each child to gain the most from school.

9. Is this a research project?	The CIU intends to look at the results and use them to plan more effective education programs for young children.
10. What are the ages of the children who are being checked?	Preschool.
11. Why are older children not being checked?	They are checked regularly in school.

Write in other questions parents asked.

APPENDIX M

Sample News Releases

The _____ is offering parents of preschool children ages six months to six years in the _____ area an opportunity to have their child's development checked. The check-up is free and takes about 30 minutes. Parents should be receiving letters sometime this week informing them of when they can bring their child in for a check up at the _____.

The check-up includes a series of simple activities to find out how well your child is developing. Four areas are checked: motor development, problem solving ability, language or communication and self-help skills. The motor development activities examine a child's ability to use his body in large and small movements as in activities such as standing up, stacking blocks, or picking up tiny objects. Problem solving checks the child's ability to do what others do and solve simple problems such as finding a hidden object or reaching an object with the help of a stick. The communication activities look at what the child can say and what he can understand when spoken to. Typical communication checks are follows directions, points to parts of his body when asked and asks for food by name. The self-help activities look at the child's ability to do skills such as feeding self and undressing.

These simple activities can provide valuable information about the child's development. This information can be helpful to parents in understanding their child. Results from the checkup will be given to each parent shortly after the check-up and all information will be kept completely confidential.

If you know of any relatives, friends or neighbors in your area who have preschool children ages six months to six years and who have not been contacted about the check-up please tell them about it. If they are interested they should call _____ between _____ and _____ for assistance. We will be pleased to help them.

APPENDIX N

Screener's Checklist

Before Test - Child

1. Child able to see and reach test materials easily.
2. Child given time to adjust to examiner/situations.
3. Child's physical comfort assured.
4. Testing items arranged systematically.
5. Distractions (observers, etc.) excluded.

Before Test - Parent

1. Explained to parent that DDST is not IQ test.
2. Explained to parent that child not expected to perform every item asked.
3. Parent asked if child born prematurely

During Test - Child

1. Child approaches in nonthreatening way at the right time.
2. Child kept occupied.
3. Child given sufficient opportunity to respond.
4. Test items presented one at a time with previous materials skillfully removed.
5. Child kept responsive by shifting items.
6. Child generally told what to do rather than asked.
7. During attempts, child given approval for effort.
8. Praise varied in words used and tone of voice.
9. Child given encouragement during failure as well as during success.
10. Difficulty of items commented on when child's ceiling approached.
11. Remarks made by the child attended to.
12. Child kept from rummaging around/wandering off.
13. When performance questionable, items were not scored based on an impression of the child.

During Test - Parent

1. Parent asked to describe child's behavior rather than questioned item by item.
2. Parent's comment clarified relative to scoring where necessary.
3. For parental reports, no answers suggested through leading questions.

During Test - Parent (Continued)

4. Parent guided in facilitating test (by limiting talk or intervention or by supplying modeling or encouragement.

After Test - Child

1. Enough items administered (3 Fs and 3 Ps in each).
2. All items on age line administered.
3. Failures (Fs) counting as delays circled.
4. Child praised.

After Test - Parent

1. Method of test followup explained.
2. Parent praised.

Screener _____

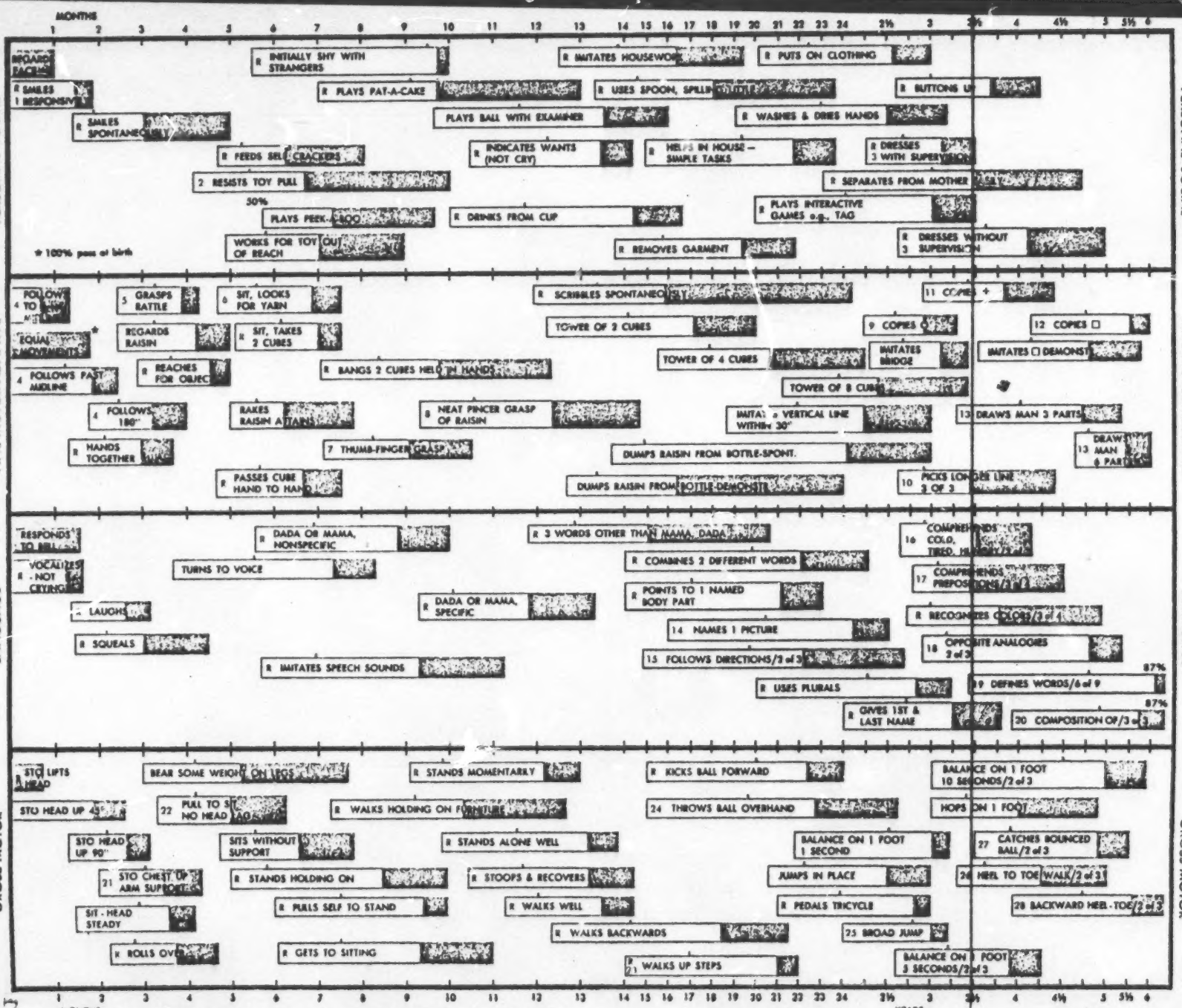
Evaluator _____

Child _____

\+ yes

\- no

NA not applicable


DENVER DEVELOPMENTAL SCREENING TEST
PERCENT OF CHILDREN PASSING
Date
Name
Birthdate
PERSONAL-SOCIAL
FINE MOTOR-ADAPTIVE
LANGUAGE
GROSS MOTOR
MONTHS
YEARS
R INITIALLY SHY WITH STRANGERS
R IMITATES HOUSEWORK
R PUTS ON CLOTHING
R PLAYS PAT-A-CAKE
R USES SPOON, SPILLS
R BUTTONS UP
PLAYS BALL WITH EXAMINER
R WASHES & DRIES HANDS
R INDICATES WANTS (NOT CRY)
R HELPS IN HOUSE – SIMPLE TASKS
R DRESSES W/ SUPERVISION
R SEPARATES FROM MOTHER
PLAYS PEEK-A-BOO
R DRINKS FROM CUP
R PLAYS INTERACTIVE GAMES e.g., TAG
WORKS FOR TOY OUT OF REACH
R REMOVES GARMENT
R DRESSES WITHOUT SUPERVISION
* 100% pass at birth
5 GRASPS RATTLE
6 SIT, LOOKS FOR YARN
R SCRIBBLES SPONTANEOUSLY
11 COPIES +
REGARDS RAISIN
X SIT, TAKES 2 CUBES
TOWER OF 2 CUBES
9 COPIES ○
12 COPIES □
TOWER OF 4 CUBES
IMITATES BRIDGE
IMITATES □ DEMONST
R REACHES FOR OBJEC
R BANGS 2 CUBES HELD IN HANDS
TOWER OF 8 CUBES
4 FOLLOWS 180°
RAKES RAISIN AT 3 IN.
8 NEAT PINCER GRASP OF RAISIN
IMITATES VERTICAL LINE WITHIN 30°
13 DRAWS MAN 3 PARTS
R HANDS TOGETHER
7 THUMB-FINGER GRASP
DUMPS RAISIN FROM BOTTLE-SPONT.
DRAWS MAN 6 PARTS
R PASSES CUBE HAND TO HAND
DUMPS RAISIN FROM BOTTLE-DEMONSTR
10 PICKS LONGER LINE 3 OF 3
RESPONDS TO BELL
R DADA OR MAMA, NONSPECIFIC
R 3 WORDS OTHER THAN MAMA, DADA
16 COMPREHENDS COLD, TIRED, HUNGRY/3
VOCALIZES - NOT CRYING
TURNS TO VOICE
R COMBINES 2 DIFFERENT WORDS
17 COMPREHENDS PREPOSITIONS/3 of 3
R DADA OR MAMA, SPECIFIC
R POINTS TO 1 NAMED BODY PART
R LAUGHS
R RECOGNIZES COLORS/3 of 4
14 NAMES 1 PICTURE
R SQUEALS
18 OPPOSITE ANALOGIES 2 of 3
R IMITATES SPEECH SOUNDS
15 FOLLOWS DIRECTIONS/3 of 3
87%
R USES PLURALS
19 DEFINES WORDS/6 of 9
87%
R GIVES 1ST & LAST NAME
20 COMPOSITION OF/3 of 3
STO LIFTS HEAD
BEAR SOME WEIGHT ON LEGS
R STANDS MOMENTARILY
R KICKS BALL FORWARD
BALANCE ON 1 FOOT 10 SECONDS/2 of 3
STO HEAD UP 45°
22 PULL TO SIT NO HEAD LAG
R WALKS HOLDING ON FURNITURE
24 THROWS BALL OVERHAND
HOPS ON 1 FOOT
STO HEAD UP 90°
SITS WITHOUT SUPPORT
R STANDS ALONE WELL
BALANCE ON 1 FOOT 1 SECOND
27 CATCHES BOUNCED BALL/2 of 3
21 STO CHEST UP ARM SUPPORTED
R STANDS HOLDING ON
R STOOPS & RECOVERS
JUMPS IN PLACE
26 HEEL TO TOE WALK/2 of 3
SIT - HEAD STEADY
R PULLS SELF TO STAND
R WALKS WELL
R PEDALS TRICYCLE
28 BACKWARD HEEL-TOE/2 of 3
R WALKS BACKWARDS
25 BROAD JUMP
R ROLLS OVER
R GETS TO SITTING
WALKS UP STEPS
BALANCE ON 1 FOOT 3 SECONDS/2 of 3
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Date 78-7-4
Name Pamela C
Birthdate 75-1-4
3-6-0

Appendix

APPENDIX P

Parent Consent Form

The Denver Developmental Screening Test was explained to me and I willingly let the series be administered to my child _____ (child's name).

_____
Parent's Name

_____
Date

APPENDIX Q

Interpreters' Questions

Interpreters are to ask and record on back side of Denver form two questions.

1. Does your child have any current serious health problem?
2. Do you have any special problem with your child or do you have any concerns about your child's development?

APPENDIX R

THE PENNSYLVANIA STATE UNIVERSITY
Division of Special Education
304 CEDAR
UNIVERSITY PARK, PENNSYLVANIA 16802

Division of Special Education
— Education of Exceptional Children
— Speech Pathology and Audiology

Area Code 814
865-1183

Sample Agency Letter "A"

Dear _____:

As a result of the screening we conducted a few weeks ago in the _____ area, and an additional follow-up rescreening at home, we discovered a number of children who do not appear to be developing as well as might be expected for their age, as based on the results of the Denver Developmental Screening Test.

Since you informed us a few months ago of your ability to provide services to children with developmental delays in the domains of _____ _____, we are enclosing a list of the children who need further assessment and possibly your services, as well as their parents' names, addresses, and phone numbers, so that you may contact them.

Thank you for your prompt attention.

Sincerely,

AN EQUAL OPPORTUNITY UNIVERSITY

APPENDIX S

THE PENNSYLVANIA STATE UNIVERSITY
Division of Special Education
304 CEDAR
UNIVERSITY PARK, PENNSYLVANIA 16802

Division of Special Education
— Education of Exceptional Children
— Speech Pathology and Audiology

Area Code 814
865-1183

Sample Parent Letter

Dear Mr. and Mrs. _____:

As a result of the screening we conducted on your child, it is our estimate that _____ is not developing quite as well as a child of his/her age would be expected. Since we know you are interested in _____'s development, as evidenced by your bringing him/her to the screening, we are sending you a listing of the agencies in the area which would be willing to administer a thorough assessment of your child to determine if _____'s delay is serious enough to require help.

Please feel free to call any of the agencies, as they will most certainly be glad to help you and your child.

Thank you for your interest.

Sincerely,

AN EQUAL OPPORTUNITY UNIVERSITY

APPENDIX T

THE PENNSYLVANIA STATE UNIVERSITY
Division of Special Education
304 CEDAR
UNIVERSITY PARK, PENNSYLVANIA 16802

Division of Special Education
— Education of Exceptional Children
— Speech Pathology and Audiology

Area Code 814
865-1183

Sample Agency Letter "B"

Dear _____:

As a result of the screening we conducted a few weeks ago, we discovered a number of children who may be eligible for your services, as based upon their failing the Denver Developmental Screening Test.

We have sent the parents of these children a letter informing them of their child's delay, and a listing of agencies such as yours which would be willing to help them. Hence, this letter is to notify you of the possibility of their contacting you as well as allowing you the option of contacting them should they not call.

Thank you.

Sincerely,

AN EQUAL OPPORTUNITY UNIVERSITY